

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED APR 15 1940  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **8766**  
Registrar's No. **2249**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 days  
(Specify whether  
In this community 50 years  
years, months or days)

3. (a) PRINT FULL NAME Hilma Cederberg

8. (b) If veteran, name war ---- 3. (c) Social Security No. ----

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased November 4, 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 4 1 hr. min.

9. Birthplace Sweden  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12. Name Issac Hamingson

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hilma Cederberg

(b) Address 353 Tacoma

17. (a) Burial (b) Date thereof 3/7/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Randolph, Kansas

18. (a) Signature of funeral director Wacker-Weldert

(b) Address 2331 S. Broadway

19. (a) MAR 6 1940 (b) J. Bruders  
(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 353 Tacoma Dr. Lemay, Mo.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 5  
year 1940 hour 11 minute 30 p. a. m.

21. I hereby certify that I attended the deceased from Feb 26, 1938  
to Mar 5, 1940  
that I last saw her alive on Mar 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 12 days

Due to Hypertension year year.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Carl Klein (M. D. or other)

Address 2632 S. Kingshighway Date signed 3-6-40

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Joseph R. Myland Jr.*

Licensed Embalmer No.....

*2675*

P. O. Address.....

*St Louis Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**